IN THE UNITED STATES PATENT AND TRADEMARK OFFICE

In re Patent Application of: Lewis, et al.	)	Confirmation No. 9722
Serial No.: 09/812,704	)	Examiner: Christopher Gilligan
Filed: March 19, 2001	)	Group Art Unit: 3626
For: ***METHODS AND SYSTEMS FOR HEALTHCARE PRACTICE MANAGEMENT***	)	Attorney Docket No. 044258.000003

DECLARATION UNDER 37 CFR 1.132

Mail Stop AF
Commissioner for Patents
PO Box 1450
Alexandria, VA 22313-1450

Sir:

I, Richard G. Fiscella, state the following:

1. I have a Bachelor of Science, in Pharmacy (1976) degree and a Master of Public Health (1985) degree. I am a Registered Pharmacist, having extensive experience in pharmacology and in academia. I have published over eighty research or review papers with an emphasis in ophthalmology, infectious diseases and pharmacoeconomics. I have been the principal or co-investigator on numerous animal and human studies; researcher and speaker for several major pharmaceutical companies and since 1982 have participated in over one hundred ocular pharmacology presentations. Moreover since 1981, I have held several professorships in pharmacy practice. I hold numerous memberships in professional societies one of which is the

Academy of Managed Care Pharmacy. I currently am a Clinical Professor in the Department of Pharmacy Practice for the University of Illinois.

2. I am familiar with and understand the subject matter of the above-identified patent application. I have studied the application and the amendments to the application and the cited patent documents of record in the application.

3. I have read and studied U.S. Patent No. 6,370,511 (hereinafter "Dang") attached at Exhibit A; I have read the article *New Compensation Model Improves Physician Productivity* authored by Alexandra Davis and C. Hardy Thompson and published in Healthcare Financial Management. July 1999, 53, 7, pg. 46 (hereinafter "Davis"), attached at Exhibit B, which outlines the development of a new compensation plan that bases pay on the application of a collection rate percentage to each physician's gross fee-for-service billings; and lastly, I have read and studied U.S. Patent No. 6,012,035 (hereinafter "Freeman") attached as Exhibit C. I also have read and studied the other patent documents cited in the U. S. Patent and Trademark Office in this matter as listed in the attached Exhibit D.

4. In my opinion, the present claimed invention, Claims 1-37, 39-46 and 51-56, advantageously provides a system and method for managing a healthcare practice which enhances profitability of the healthcare practice and is unique and operationally quite different than other systems and methods I have seen before and as set forth in the patent documents at Exhibits A, B and C. It is my opinion that the claimed invention, Claims 1-37, 39-46 and 51-56 would not be obvious to one of ordinary skill in the art at the time this application was filed. It is also my opinion that one skilled in the art would lack motivation to combine Dang and Davis or Dang, Davis, and Freeman to somehow arrive at the claimed invention.

5. For example, in my opinion, the present claimed invention transforms physician's cost management behavior to enhance profitability of healthcare practices and insurance networks by identifying physicians that are not profitable because of cost management behavior and provides a method and system of intervention to change the management behavior of the physician. Further, the establishment of cost norms with predetermined reimbursement amounts would not be an obvious development in view of the patent documents cited at Exhibits A, B and C, individually or in combination.

6. I believe that the present claimed invention offers a viable solution for measuring and controlling costs and cost-effectiveness of care. The present claimed invention will provide an important contribution to healthcare management.

7. Also, for example, as reasons for lack of motivation to combine these patent documents and for lack of obviousness of the claimed invention, management can be defined in three areas: to administer, control and cope. The Freeman and Dang patents focus on *"administration";* whereas, the present claimed invention focuses on cost *"control".* When addressing a change program, the process must address: (1) what to change, (2) what to change to, and (3) how to cause or affect the change. Freeman and Dang show which cooperative entity is responsible for the costs. Dang quantifies the costs and compares them to others on an adjusted basis. The present claimed invention is *critical* because in cost control it shows how to *cause or affect the change.* Freeman and Dang *do not offer* a change process or solution. The present claimed invention *offers* a solution for measuring or controlling costs and cost-effectiveness of care.

8. Also, for example, as additional reasons, the Davis article describes *revenue;* the present claimed invention describes *expenses.* Davis requires physicians to *increase* their gross billings to *maximize* their reimbursement. According to Davis, this behavior modification induces physicians to increase billing revenues through marketing to increase the number of patients and to increase the prescription of ancillary testing services to maximize billings per patient. It does not focus on measuring or controlling costs. Rather, Davis deals strictly with physicians on the payroll of a specific healthcare organization and offers a change process or measurement system which *assumes* the physicians will only take the clinically appropriate steps to increase their measures. Increased productivity does not necessarily increase the quality of care or control costs; however, it most assuredly will increase the workload of the physician. The present claimed invention employs physician behavior modification, for example, in the areas of increased utilization of step therapies, greater training in clinical prescribing guidelines, and tools to counsel patients on the perils of starting new treatment with last-line, high cost drugs, all of which are cost control measures.

9. Again, for at least these reasons, it is my opinion that the claimed invention would not be obvious to one of ordinary skill in the art.

10. I hereby declare that all statements made herein of my own knowledge are true and that all statements made on information and belief are believed to be true; and further that these statements were made with the knowledge that willful false statements and the like so made are punishable by fine or imprisonment, or both, under Sec. 1001 of Title 18 of the United States Code and that such willful false statements may jeopardize the validity of the publication or any patent issued thereon.

FURTHER DECLARANT SAYETH NOT.

6/17/05
Date

By: Richard G. Fiscella

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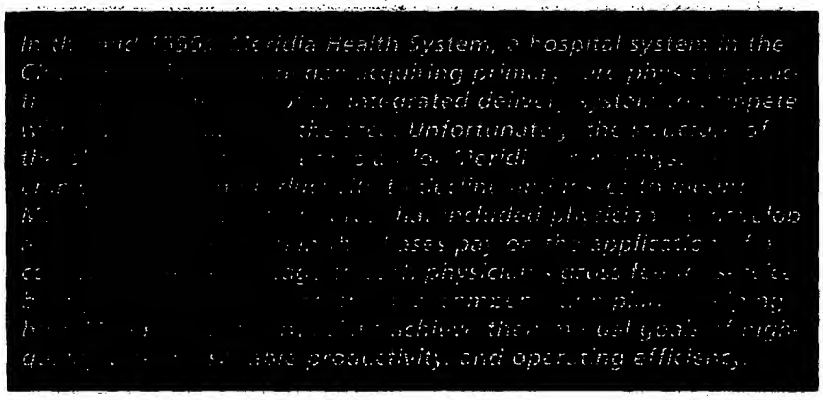
Physician productivity

An Ohio system incentive plan rewards physicians for achieving high-quality care, improved productivity, and operations efficiency.

BY ALEXSANDRA DAVIS, MPA, AND C. THOMPSON HARDY, MHA, FACMPE



Hospitals and health systems that have attempted to protect and expand their patient bases by buying physician practices are finding that high overhead costs and declines in physician productivity are making this strategy unprofitable. Numerous surveys have found that hospitals have been incurring annual losses of as much as $100,000 per acquired physician.

Healthcare organizations that are trying to increase the productivity of their employed physicians often find that the physicians lack sufficient financial incentives and managerial skills to meet desired productivity levels. One health system in the Cleveland, Ohio, area, however, has rejuvenated the performance of its physician network by overhauling its physician compensation program and introducing effective incentives.

Forming a Primary Care Network

Since its formation through the merger of four independent hospitals in the 1980s, Meridia Health System has enjoyed a strong market position in Cleveland's eastern suburbs. Competition in the Cleveland healthcare market, however, has gradually intensified as a result of hospital consolidations, the acquisition of independent hospitals by for-profit hospital systems, and the development of integrated delivery systems (IDSs) that incorporate health plans, physician practices, and ancillary services into hospital-owned networks.

In 1992, Meridia decided that to remain competitive it had to develop a primary care physician network to form the core of an IDS. By 1995, through practice acquisitions and expansions, Meridia was operating four primary care practices employing a total of about 40 primary care physicians. An independent company was engaged to provide billing and management services for the network.

All physicians received two- or three-year guaranteed salary and benefit packages. Salaries were based on a review of each physician's existing salary level and years of experience, as well as industry compensation surveys. Benefit packages mirrored those of Meridia's senior executives, though some were modified to fit individual circumstances. Bonuses were available for physicians who met productivity targets. Most of these targets were based on a combination of the historical production level of each individual physician and industry averages.

Disappointing Network Results

Meridia executives had assumed that their physician practices would continue to function as they had before they were acquired. This assumption proved faulty for several reasons.

First, physician productivity declined for a variety of reasons. For example, many physicians spent less time in the office, saw fewer patients, and provided fewer services than they had before their practices were acquired.

Second, the transition to using contracted billing and management services caused disruptions to routine practice operations. These disruptions were compounded by the contracted company's failure to perform collection services adequately or develop management reports and distribute them in a timely fashion.

Third, new physicians recruited into the groups placed increased demands on practice resources and absorbed existing and new patient volume. The latter

occurrence limited the opportunities of established physicians within the practices to maintain current productivity levels, let alone increase them.

10 Fourth, as practice sites were expanded or consolidated into new facilities, practice operations were disrupted. Patient volumes dropped in part due to practice location changes.

11 Losses from primary care network operations were in excess of $100,000 per physician, per year. In response, Meridia placed a moratorium on physician recruitment and practice acquisitions. A practice management and billing system was acquired and implemented internally. In addition, the practice administrative staff was restructured and augmented, with the hospital system's human resources and accounting departments assuming expanded responsibilities for network operations.

Revamping the Compensation Plan

12 A prime target of Meridia's loss-reduction effort was physician compensation. The system established a budget-reduction target for physician compensation of approximately $500,000, roughly 14 percent of current compensation levels.

13 Accordingly, a new compensation plan was proposed. Each physician was guaranteed a salary of 50 percent of the industry compensation standard, as determined by examining surveys of the Medical Group Management Association, the Society of Medical and Dental Consultants, and the American Group Management Association, with the opportunity to earn up to 100 percent of the standard, depending upon the practice's achieving collection levels equal to the industry collection standard. Financial projections predicted that 36 percent of the physicians would earn higher salaries under the proposed plan, while 64 percent would earn an average of $20,000 per year less than their current compensation.

14 The plan seemed good in theory because it was based on industry standards and offered significant incentives to improve performance. After several meetings with the physicians, however, it was clear that the plan never would be implemented. Physicians felt it was imperative that they have a say in developing the physician compensation model, and they would not accept a plan that was mandated by administration.

15 Meridia therefore pursued a different direction. The system began by formally establishing a physician compensation task force composed of all its physician group presidents, additional physician representatives, and representatives from Meridia's practice management, human resource, and finance and accounting departments. A two-to-three-month time frame for development of a compensation plan was established.

16 The task force addressed the following issues:

- Assessment of current Meridia practice management services;
- Assessment of physician practice activities and results;
- Development of conceptual goals for physician compensation strategies;
- Identification of key problems associated with incentive-based compensation models and methods to resolve them;
- Identification of alternative compensation models;
- Selection of a compensation model; and
- Introduction of the model to physicians and implementation of the plan.

17 Early in the process, gross billings by physicians were chosen as a measure of physician activity. After the gross billing was compared with industry standards, it became apparent that physician productivity was not as low as had been indicated by Meridia's earlier assessment of collections. Although some physicians still were "overpaid" relative to industry standards, the percentage of physicians with pay significantly over industry averages was not nearly as dramatic as the earlier projection of 64 percent.

18 Based in part on these findings, the task force developed the following goals for the compensation plan:

- *The plan should provide reasonable and fair compensation to all physicians based on practice activities and results that physicians can control.* This goal required the physicians to concede that compensation would vary from physician to physician and that receipt of historical compensation levels could not be guaranteed. Similarly, Meridia-controlled factors, such as billing and collection systems and payer mix at practice locations, would not impact physician salary negatively.
- *The compensation plan should be flexible enough to accommodate unique aspects of each group and the market's transition to capitation.*
- *The plan should include different incentives to compensate physicians on their individual performance, their group's results, and the results of the network as a whole.* These multilevel incentives were needed to demonstrate to the physicians that, as employees, they are accountable not only for their individual activities

but also for the effect of those activities on group and network results.

- *The new compensation plan should be phased in.* A phased approach would ensure that the system would be able to provide information on practice performance to the physicians in a timely fashion, that physicians would understand the impact of their performance on their new compensation, and that physicians could effect changes in practice activities to achieve their compensation goals.

The New Compensation Plan

19 Physicians receive a one-to-two-year salary guarantee at time of employment. Then the compensation plan developed based on the task force's identified objectives comes into force.

20 Due to physician and administration skepticism regarding historical collection results obtained through the contracted billing and management company and the limited experience with the new in-house billing system, a collection rate of 68 percent (calculated collections) was selected arbitrarily to be applied to physician gross fee-for-service billings. (Other practice revenues, such as capitation and administrative stipends, were considered 100 percent collectible.) Physician salaries are based on the application of a practice overhead rate (representing practice expenses and physician benefit costs) of 58 percent to calculated collections up to $275,000 and 50 percent to collections over this amount. This straightforward approach to compensation incentives addresses the highest priorities for the network: boosting productivity and improving operating efficiency.

21 To determine physician compensation, the network reviews each physician's productivity during the most current 12-month period and determines the calculated collections he or she generated. This amount then is multiplied by the applicable overhead rate, and the balance remaining after deducting overhead from the collections figures represents the physician's total budgeted salary.

22 The physician then is paid 100 percent of that amount for the next six months. If, at the end of six months, the physican falls below his or her targeted productivity level, the physician's salary is adjusted downward to a maximum 35 percent reduction. If the physician's productivity level is above the target, he or she receives a bonus based on the appropriate 58 percent and 50 percent overhead rates previously mentioned. This amount is paid immediately or put into escrow, if the physician wishes, to use to supplement his or her income should the physician's earnings decrease in the future.

23 Following approval of the plan, all physicians began to receive monthly reports that showed their current production and what their compensation would be under the new plan compared with their current salary. The group presidents were responsible for helping the physicians interpret the results and develop strategies to achieve their compensation goals. Administration committed to providing accurate reports of practice results within three working days of the end of the month.

24 A standing committee was established to monitor the compensation plan results and to monitor and modify the practice activities to ensure that the incentives of the compensation plan were producing the desired results.

Results and Conclusion

25 Results of the new compensation plan have been positive. In the first year, 25 physicians were compensated under the new plan: 13 of these physicians exceeded the budget target for their practices, generating $400,000 over budget in revenues. Increases in practice productivity ranged from 10 to 25 percent. Patient encounters also increased by 6,000 visits among the 25 physicians on the plan.

26 Actual network overhead costs are shrinking, and the relationship between the physicians and administration has improved. Physician participation in educational programs on topics such as billing, coding, chart documentation, clinical protocols, and utilization management has improved, and most importantly, practice patterns are changing.

27 One group has already modified the compensation plan by withholding 10 percent of the budgeted compensation and distributing the withheld amount to its physicians based on the results of patient satisfaction surveys. Financial results compared with budget for each group are being monitored and will be introduced as an incentive component of the plan next year. Additional elements of practice activities and results, including RVU output per physician and patient-severity weighting, are being tracked and reported for potential future incentive applications.

28 The transition has not been without turmoil. Several physicians have left the network, and a number of others have seen their pay reduced and have received intensive counseling on their professional practices. Nonetheless, a general consensus among physicians has been reached regarding the long-term benefits of the new compensation plan and the need for teamwork. The physician

group presidents have begun to exert leadership through this process and are now an integral component of Meridia's management team.

29 Meridia Health System recognizes that its compensation plan is a work in progress. It is important for hospitals and health systems to be realistic about what a compensation plan can and should accomplish and test the incentive compensation models to ensure they produce the desired outcomes. To effectively modify behavior, physicians need to receive consistent reports and feedback.

30 Any physician compensation plan must have physician buy-in to work. Physicians understandably will not react well to a mandate from administration regarding the sensitive issue of compensation. Therefore, the best way to achieve this buy-in is to involve physicians in developing the plan right from the start and patiently, effectively facilitate their participation.

31 Meridia's compensation plan is not perfectly fair—no compensation plan ever will be. However, through good-faith negotiations and compromise, Meridia and its primary care physicians were able to develop a workable compensation system that is helping both parties achieve their mutual goals of high-quality care, appropriate productivity, and operating efficiency. ■

ABOUT THE AUTHORS

Alexsandra Davis, MPA, is vice president of business development, Physician Business Systems, Independence, Ohio.

C. Thompson Hardy, MHA, FACMPE, is director, New Health Management, Inc., Cleveland, Ohio.

FORM PTO-1449
LIST OF PATENTS AND
APPLICANT'S INFORMATION DISCLOSURE STATEMENT

ATTORNEY DOCKET NO.: 24995

SERIAL NO.: 09/812,704 FILING DATE: March 19, 2001

APPLICANT: Lewis et al. GROUP:

REFERENCE DESIGNATION U.S. PATENT DOCUMENTS

EXAMINER INITIALS		DOCUMENT NUMBER	DATE	NAME	CLASS	SUB CLASS	FILING IF APPROPRIATE
	AA	5,557,514	9/17/96	Seare et al.	364	401	
	AB	5,706,441	1/6/98	Lockwood	395	203	
	AC	5,724,379	3/3/98	Perkins et al.	395	202	
	AD	5,835,897	11/10/98	Dang	705	2	
	AE	5,918,208	6/29/99	Javitt	705	2	
	AF	5,953,704	9/14/99	McIlroy et al.	705	2	
	AG	6,195,612	2/27/01	Pack-Harris	702	2	
	AH	6,223,164	4/24/01	Seare et al.	705	2	
	AI	20010037216	11/1/01	Oscar, Robert S., et al	705	2	
	AJ	20010041990	11/15/01	Javitt, Jonathan C.	705	2	

FOREIGN PATENT DOCUMENTS

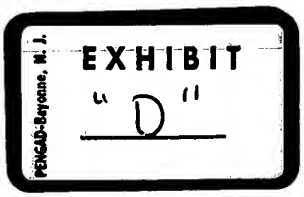
		DOCUMENT NUMBER	DATE	COUNTRY	CLASS	SUBCLASS	TRANSLATION Yes -- No
	AK						

OTHER ART
(Including Author, Title, Date, Pertinent Pages, etc.)

	AL		Information Disclosure Declaration of Charles C. Lewis and Terrance Moore
	AM		
	AN		
	AO		

EXAMINER: DATE CONSIDERED:

EXAMINER: Initial if reference considered, whether or not citation is in conformance with MPEP 609; * Draw line through citation if not in conformance and not considered. Include copy of this form with next communication to applicant.



IN THE UNITED STATES PATENT AND TRADEMARK OFFICE

In re Patent Application of: **LEWIS ET AL.**	
Serial No.: **09/812,704**	Attorney Docket No.: **24995**
Filing Date: **MARCH 19, 2001**	
For: **METHOD AND SYSTEM FOR HEALTHCARE PRACTICE MANAGEMENT**	

Hon. Commissioner of Patents and Trademarks
Washington, D.C. 20231

Sir:

INFORMATION DISCLOSURE DECLARATION OF CHARLES C. LEWIS AND TERRANCE MOORE

The purpose of this joint declaration is to bring to the attention of the U.S. Patent and Trademark Office, pursuant to 37 C.F.R. §1.98, the following circumstances directed to experimental testing of functional features of the presently claimed system and methods

1. We, Charles Lewis and Terrance Moore, are co-inventors of the invention disclosed in U.S. Patent Application Serial Number 09/812,704, titled "*Method And System For Healthcare Practice Management*" which was filed on March 19, 2001 and is related to U.S. Patent Application Serial Number 09/812,703

titled "*Methods For Collecting Fees For Healthcare Management Group*".

2. In 1975, Charles Lewis received a Bachelors of Science in Pharmacy from the University of Pittsburgh School of Pharmacy. In 1998, Mr. Lewis received a Masters of Business Administration from the University of Phoenix.

(A) Mr. Lewis is a Registered Pharmacist in the States of Florida, Nevada, and Pennsylvania.

(B) Mr. Lewis is a Registered Consultant Pharmacist in the State of Florida.

(C) In 1992, Mr. Lewis served on the Legislative Affairs Committee for the Florida Pharmacy Association.

(D) In 1996, Mr. Lewis served on the Curriculum Advisory Committee at the University of Florida School of Pharmacy.

(E) In 1997, Mr. Lewis served as a Florida Legislative Liaison for the Academy of Managed Care Pharmacy.

3. Mr. Lewis is a member in good standing of the following groups and associations:

(A) American Society of Health System Pharmacists;

(B) American Society of Consultant Pharmacists;

(C) Academy of Managed Care Pharmacy; and

(D) American Society of Consultant Pharmacists.

4. We are co-owners of The Jasos Group (Jasos), which was founded in August 2000 and is the assignee of the above-referenced patent applications. Mr. Lewis is the original founder of Jasos and has been the Managing Partner of Jasos since its inception. Mr. Moore met Mr. Lewis in November 1998 and joined Jasos in August 2000.

5. Mr. Lewis has been employed in the fields of pharmacy and pharmacy management for over 26 years. In those 26 years, Mr. Lewis has owned a pharmacy, and has worked as a pharmacist, a pharmacy consultant to the State of Florida, and a licensed private investigator conducting investigations concerning health related issues.

6. Between December 1992 and December 1998, Mr. Lewis was employed as a clinical coordinator for Prudential Health Care (Prudential). The responsibilities of this position included drug utilization reviews and evaluations, formulary management,

and generation of analytical reports to monitor and reduce per member per month (PMPM) costs. In December 1998, Mr. Lewis resigned his position with Prudential to pursue a consulting position in the field of pharmacy management with Physicians Pharmacy Practices, Inc. (P3).

7. Between 1992 and 1998, Mr. Lewis, conceived, developed, and tested "bits and pieces" of a system that would later be reduced to practice as the system and methods of the above-referenced patent applications. More particularly, the "bits and pieces" that were conceived and developed were directed to a system and methods to monitor and reduce PMPM costs using various cost management techniques. At that time, the "bits and pieces" that were conceived, developed, and tested included collecting and analyzing pharmacy data and statistically identifying physicians whose behavior resulted in elevated PMPM costs. More particularly, these "bits and pieces" included:

(A) identifying those prescribers whose drug expenditures were greater than three standard deviations above a calculated mean;

(B) of those prescribers, determining who had generated the number of prescriptions greater than two standard deviations above the mean; and

(C) of those prescribers, determining who had average costs per prescription above the mean. These prescribers were thereafter identified as outliers.

(D) Once the outliers were identified, report cards were generated and mailed. Monthly fax newsletters were transmitted to all primary care physicians. The reports were then reviewed with the primary care physicians on a one-on-one basis.

(E) While developing and testing these "bits and pieces" of a system, the steps involved in analyzing the collected data were not disclosed. All individuals that assisted in the development and testing of the "bits and pieces" of a system described above did so under Mr. Lewis' guidance and surveillance. At no time was information regarding the analysis of the data or the methods used to analyze the data disclosed. The analysis of data was kept confidential. At no time during the development and testing

was control relinquished of the above referenced "bits and pieces".

(F) During the later part of the period between 1992 and 1998, i.e., between 1997-1998, the above-referenced "bits and pieces" were accumulated to form a preliminary system and methods of the above-referenced patent applications. At no time before 1998, however, were the systems and methods of the above-referenced patent applications ever tested in their entireties.

8. After Mr. Lewis joined P3, it was determined that the above-referenced system and methods needed to be further tested. To further test the above-referenced systems and methods, P3 entered into confidential agreements with Telesis Health Management (Telesis) of Louisville, KY and Deaconess Health Connection (Deaconess) of Evansville, IN. Telesis and Deaconess were chosen by P3 to participate in the confidential testing of the above-referenced system and methods because they met the criteria of what was considered to be a viable future client at the time. The characteristics of a viable future client at that time included:

(A) a future client that was at risk for pharmacy costs;

(B) a physician based organization, i.e., physician practice management companies, independent physician associations (IPA's), or management services organizations (MSO's); and

(C) a future client was not an insurer or a pharmacy benefit manager (PBM).

9. P3 entered into two separate confidential agreements with Telesis and Deaconess to better test the above-referenced systems and methods by trying to duplicate test results.

10. The confidential testing of the above-referenced system and methods using Telesis commenced in October 1998.

(A) More specifically, P3 confidentially tested the system and methods to lower PMPM costs for Telesis in an effort to perfect the system and methods.

(B) The scope of the work performed for Telesis included collecting data provided by Telesis, analyzing that data, and presenting the results of the analysis to Telesis. All individuals from P3 that assisted in the confidential testing did so under Mr. Lewis' guidance and surveillance. At no time was

Telesis ever provided any information regarding the analysis of the data or the methods used by P3 to analyze the data. The analysis of any data was kept confidential by P3. At no time during the confidential testing of the system and methods did P3 or Mr. Lewis relinquish control of the system and methods.

(C) P3 collected quarterly payments to cover out-of-pocket expenses to cover costs of operating the systems and methods so that P3 could begin to test the systems and methods. Telesis also agreed to pay all expenses, i.e., travel expenses, incurred by P3 when testing the above-referenced system and methods. Telesis further agreed to pay a small percentage of PMPM cost savings to P3 during the testing period. The total savings recognized by Telesis during the testing of the systems and methods, however, were inconclusive due to the lack of integrity of the pharmacy claims data provided by Telesis. Therefore, since the cost savings was inconclusive, P3 received no cost savings payment. The primary purpose of the work for Telesis was experimental.

(D) Representatives from P3 and Telesis met monthly to exchange feedback regarding the progress of the confidential test. Some of the problems that were recognized during the confidential testing of the system and methods included:

- a lack of integrity of the pharmacy claims data provided by Telesis;
- reluctance to assist with data collection on the part of the insurers and the insurer's PBM;
- increased travel expenses due to scheduling of the system being controlled by the clients, which made for many unnecessary meetings that required personnel for P3 to travel to various locations to meet with representatives from Telesis, as well as physicians in the Telesis network;
- physicians were reluctant to "buy in" to the system and methods being tested because they did not see any incentive for them;
- academic detailing of all prescribers; and

- inability to determine exactly what savings were realized by P3's efforts due to lack of data integrity.

(E) In order to solve the problems that were recognized during the confidential testing, the system and methods were further developed to include:

- developing a time-line for academic detailing and client management visits;
- focus on academically detailing only those prescribers who are statistical outliers;
- put P3 in charge of scheduling so as to optimize resources of P3 representatives;
- perform due diligence review with respect to data integrity and benefit design; and
- investigate other ways to measure savings in other areas, i.e., PBM performance.

(F) P3 terminated the confidential test in December 1999, one year after commencing the confidential test. Although Telesis wanted to renew the contract, P3 declined any renewal as

the system and methods were still being further developed and tested.

(G) At no time was the confidential testing of the system and methods by P3 for Telesis made public.

11. Another confidential test of the above-referenced system and methods was performed by P3 for Deaconess Health Connection (Deaconess) of Evansville, IN. The confidential test commenced in December 1998.

(A) More specifically, P3 confidentially tested the system and methods as described above to lower PMPM costs for Deaconess in an effort to perfect the system.

(B) Again, the test of the above-referenced system and methods for Deaconess was performed confidentially, i.e., Deaconess was not provided any information as to the analysis of the data. Deaconess was provided the results of the analysis. All individuals from P3 that assisted in the testing did so under Mr. Lewis' guidance and surveillance. At no time was Deaconess ever provided any information regarding the analysis of the data or the methods used by P3 to analyze the data. The analysis of

any data was kept confidential by P3. At no time during the testing of the system and methods did P3 or Mr. Lewis relinquish control of the system and methods.

(C) P3 collected quarterly payments to cover out-of-pocket expenses to cover costs of operating the systems and methods so that P3 could begin to test the systems and methods. Deaconess also agreed to pay all expenses, i.e., travel expenses, incurred by P3 when testing the above-referenced system and methods. Deaconess further agreed to pay a small percentage of PMPM cost savings to P3 during the testing period. This time around, with the Deaconess test, unlike Telesis, the test worked and cost savings were realized. Of savings amount realized, P3 was paid a small percentage. The primary purpose of the work for Deaconess was experimental.

(D) Representatives from P3 and Deaconess met monthly to exchange feedback regarding the progress of the test. Some of the problems that were recognized during the testing of the above-referenced system and methods included:

- new treatment guidelines needed to be implemented because the treatment guidelines that were set up for Telesis were insufficient for Deaconess;
- there existed inconsistency in determining which pharmacy costs were to be used in establishing a benchmark PMPM; and
- the notification process to prescribers for academic detailing had to be modified from Deaconess from the process used during the test conducted for Telesis.

(E) In order to solve those problems, the system and methods were further developed to include:

- customized treatment guidelines to fit regional practice requirements;
- agreement before the commencement of the contract which pharmacy cost figures would later be used to calculate total savings and fees; and

- increase communication with client concerning the optimal method of scheduling appointments for academic detailing visits.

(F) P3 terminated the test in December 1999, one year after commencing the confidential test. Although Deaconess wanted to renew the contract, P3 declined any renewal as the systems and methods were still being further developed and tested.

(G) At no time was the testing of the system and methods by P3 for Deaconess made public.

12. The above-referenced monies that were received by P3 were for the purpose of covering costs during the implementation and testing of the above-referenced system and methods. This is evidenced by the fact that P3 was not profitable during the time that testing was conducted of the above-referenced system and methods for Telesis and Deaconess, namely during 1999.

13. After the one year confidential tests were performed using the Telesis network and the Deaconess network, further development was necessary to solve the problems with the system that became apparent during testing.

14. P3 was purchased by Preferred Physicians Healthcare Alliance (PPHA) in June 1999. Although further development of the above-referenced system and methods was required, PPHA had difficulty in obtaining the necessary investor capital to launch a pharmacy management business. PPHA subsequently abandoned the pharmacy management business.

15. In order to further develop and launch the above-referenced system and methods, Mr. Lewis founded Jasos with Mr. Moore in August, 2000.

16. Mr. Moore received a Bachelors of Science in Mechanical Engineering from the University of Florida in 1990. Mr. Moore further obtained a Masters in Business Administration from Rollins College in 1995.

17. In April, 2000, Mr. Moore joined Mr. Lewis in laying the groundwork for what would eventually become Jasos. Mr. Moore assisted in further developing the above-referenced system and methods by:

(A) developing operational and financial structure of the system and methods of the above-referenced patent applications;

(B) developing a fee-based product for those clients who prefer an option to above-referenced system and methods.

18. Based on the performance of the above-referenced system and methods, the results of the confidential tests conducted on the above-referenced system and methods, and the problems recognized during the confidential tests, we made substantial improvements and continued to develop the above-referenced system and methods in an effort to perfect it. On March 19, 2001, U.S. Patent Application Serial Nos. 09/812,704 and 09/812,703 were filed on the inventions as tested and developed as described above. The improvements that were made to the system and methods during development and perfection that occurred after testing included incentivizing physicians in the healthcare networks, making changes to payment schedules and cost responsibilities, target markets, and physician training.

19. Both contracts between Telesis, Deaconess, and P3 included confidentiality clauses. Under the confidentiality clauses, all parties are bound not to disclose the terms of the

contract or patient information during the period of the contract and thereafter.

20. In a good faith effort to meet its duty of candor with the Patent Office, Jasos desires to disclose these facts as described above to the Patent Office during the prosecution of the above-referenced patent application.

21. We hereby declare that all statements made herein of our own knowledge are true and that all statements made on information and belief are believed to be true; and further that these statements were made with the knowledge that willful false statements and the like so made are punishable by fine or imprisonment, or both, under Section 1001 of Title 18 of the United States Code and that such willful false statements may jeopardize the validity of the application or any patent issued thereon.

In re Patent Application of:
LEWIS ET AL.
Serial No. **09/812,704**
Filed: **March 19, 2001**

12/26/01
Date

CHARLES C. LEWIS

12/26/01
Date

TERRANCE MOORE

Notice of References Cited	Application/Control No. 09/812,704	Applicant(s)/Patent Under Reexamination LEWIS ET AL.	
	Examiner Luke Gilligan	Art Unit 3626	Page 1 of 1

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	B	US-6,014,631 A	01-2000	Teagarden et al.	705/3
	C	US-6,385,589 B1	05-2002	Trusheim et al.	705/2
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*A copy of this reference is not being furnished with this Office action. (See MPEP § 707.05(a).)
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Substitute for form 1449A/PTO				Complete if Known	
INFORMATION DISCLOSURE STATEMENT BY APPLICANT				**Application Number**	09/812,704
				Filing Date	March 19, 2001
				First Named Inventor	Lewis et al.
				Group Art Unit	3626
(use as many sheets as necessary)				**Examiner Name**	Gilligan
Sheet	1	of	1	**Attorney Docket No.**	044258.03

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Exr Initials	Include Name of first Author (in CAPITAL LETTERS), title of the article (where appropriate), title of the item (book, magazine, journal, serial, symposium, catalog, etc.), volume-issue number(s), page(s), date (in parentheses). If a book, also include publisher and city and/or county where published.	T_1
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Examiner Signature		Date Considered	

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